Master Group Application (For groups of 101 and above)

blue california

Blue Shield of California and
Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

Section 1 – Company information

1

Full legal business name of group	Requested effective date of coverage (month/day/year):
Doing business as (DBA), if applicable:	County location of physical address

2

Billing street address (if providing P.O. Box, also complete #3 below)		
City	State	ZIP code

3

Physical address (if different from above)		
City	State	ZIP code

4

Legal entity type: ☐ S-Corporation ☐ C-Corporation ☐ Partnership ☐ Sole proprietorship ☐ LLC ☐ Nonprofit
☐ Other (specify) ______________________________

Federal Employer Tax Identification (TID) number ______________________________

Is the group subject to ERISA? ☐ Yes ☐ No

5

Is the group intending to offer Blue Shield alongside another carrier's plan? ☐ Yes ☐ No

Other carrier initial effective date of coverage (month/day/year):

Does the group have any subsidiary or affiliated companies? ☐ Yes ☐ No

If yes, please provide the following:	Tax ID number	Include in coverage?
Legal name 1		☐ Yes ☐ No
Legal name 2		☐ Yes ☐ No
Legal name 3		☐ Yes ☐ No

Are all employees covered by workers' compensation to the extent required by law?

☐ Yes Carrier name: ______________________________

☐ No If no, please explain: ______________________________

Blue Shield of California is an independent member of the Blue Shield Association C14939-CORE-REV-FF (1/22)

6	Group contact for:		
	Overall group contact (primary)	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Online administrator contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Billing contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Evidence of Coverage/ Certificate of Insurance (EOC/COI) contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Legal contact (accountable for binding legal commitments on behalf of employer group)	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Account Based Health Plan (ABHP) contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	COBRA administrator contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Enrollment Discrepancy Report contact (if utilizing EDI for electronic enrollment)	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Additional contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Additional contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)

Section 2 – Eligibility

7

Will you be utilizing an EDI electronic file for your ongoing enrollment? ☐ Yes ☐ No
If yes, will your COBRA members be included on that file? ☐ Yes ☐ No

Employment-based affiliation and waiting periods – An employer may impose a bona fide employment-based orientation (affiliation) period for new employees which cannot exceed 30 days. A waiting period may also be imposed before coverage becomes effective, beginning the first day after any orientation period and not to exceed a combined total of 90 days.

Please note: An employee's "date of hire" is the first day employment begins. However, if the employer imposes an orientation or waiting period, the "effective date of coverage" is the first day after completion of any orientation/waiting period.

7a. Employer waiting period – The group may select one or more of the following options.

Coverage for eligible employees will become effective following completion of the waiting period on the day specified.

If there are multiple waiting period options based on employment classification, please indicate at the option selected:

☐ **No waiting period (effective date of hire)**
- ☐ All employees
- ☐ Other (please describe) ______________________________

☐ **Effective first of the month FOLLOWING DATE OF HIRE**

a. ☐ If hired on the 1st of the month, coverage **effective 1st of following month**.
Example: employee hired 12/1/2019 = effective 1/1/2020
- ☐ All employees
- ☐ Other (please describe) ______________________________

b. ☐ If hired on the 1st of the month, coverage **effective on date of hire**.
Example: employee hired 12/1/2019 = effective 12/1/2019
- ☐ All employees
- ☐ Other (please describe) ______________________________

☐ **Effective first of the month FOLLOWING 30 DAYS FROM DATE OF HIRE**
- ☐ All employees
- ☐ Other (please describe) ______________________________

☐ **Effective first of the month FOLLOWING 60 DAYS FROM DATE OF HIRE**

Example: employee hired 12/15/2019 add 60 days= effective 3/1/2020
- ☐ All employees
- ☐ Other (please describe) ______________________________

☐ **Effective on the 91st DAY FOLLOWING DATE OF HIRE**

7b. Will the waiting period be waived:

☐ Yes ☐ No For current, actively at-work employees enrolling during the initial transition to Blue Shield.

☐ Yes ☐ No For part-time employees upon attaining full-time status.

☐ Yes ☐ No If "Yes", the waiting period should be waived for employees rehired within:
☐ 1 month ☐ 90 days ☐ 3 months ☐ 6 months ☐ 12 months ☐ 13 weeks ☐ Anytime, effective date of rehire
☐ Anytime, effective first of month following date of rehire

Please note: If using EDI electronic file for ongoing enrollment and eligibility, the member effective dates are calculated by the dates on the EDI files and the applicable waiting period(s).

8 Employee count

Blue Shield asks the group to read these definitions of "employee" and provide the information requested using the definitions provided below. We rely upon the information provided by the group in determining group and employee eligibility for coverage.

1. **All employees** – Any individual employed by the group including full-time and part-time employees, (29 USC 1002 (6)).
2. **Full-time employee (FTE) and FTE Equivalent** – FTE and FTE Equivalent is defined in Section 4980H(c)(2) of the Internal Revenue Code.

   An FTE is an employee who has on average at least 30 hours of service per week, or at least 130 hours of service total, during a calendar month.

   The number of FTE Equivalents is determined by combining the number of hours of service of all non-FTEs for the month, but no more than 120 hours of service per employee, then dividing the total number by 120.
3. **Eligible employee** – This definition is used to determine which employees are eligible to enroll, and remain enrolled, in coverage. An eligible employee is an individual who:
   - Is an individual engaged on a full-time basis in the conduct of the business of the employer, whose normal work week is at least 30 hours, and whose duties in such employment are performed at the employer's regular places of business; or
   - Is a sole proprietor or partner of a partnership engaged on a full-time basis, at least 30 hours per week, in the employer's business and who is included as an employee under a healthcare plan contract of the employer.
   - An eligible employee does not include individuals working on a part-time, temporary, or substitute basis.

8 a. Total # of employees:

8 b. Total # of eligible full-time employees:

8 c. Total # of eligible employees enrolling in Blue Shield coverage (complete to the best of your knowledge):

8 d. Total # of eligible employees declining Blue Shield coverage (complete to the best of your knowledge):

8 e. Total # of FTE and FTE Equivalents:

8 f. Do you plan to offer Blue Shield coverage to out-of-state employees? ☐ Yes ☐ No

If yes, how many out-of-state employees do you have? ________________

Employer is responsible for collecting and retaining Refusal of Coverage forms, as well as providing the forms to Blue Shield upon request. If no Blue Shield medical plan is offered (e.g., dental, vision, or life insurance only), Refusal of Coverage forms are not required.

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9a. Are all full-time eligible employees being offered health coverage?	☐ Yes	☐ No
9b. If the response to 9a is no, please explain:		
9c. Are all full-time eligible employees being offered health coverage actively working at least 30 hours per week?	☐ Yes	☐ No
9d. If the response to 9c is no, please explain:		
9e. Are retirees eligible for benefits? Note: Retiree coverage option requires prior underwriting approval.	☐ Yes	☐ No
9f. If the response to 9e is yes, please check any that apply: ☐ Early retirees under age 65 ☐ Retirees age 65 and over Will the group contribute to retiree coverage?	☐ Yes	☐ No
9g. Do you require your retiree coverage to be billed separately from your active employee population?	☐ Yes	☐ No

If yes, provide the contact information and address to which the monthly bill should be sent for retiree coverage.

Billing address		
City	State	ZIP code
Contact name	Email address	

Section 3 – COBRA/Cal-COBRA continuation coverage information

10 Your group is subject to federal COBRA if you employed 20 or more employees during at least 50% of the working days in the previous calendar year. The group is solely responsible for all aspects of the administration of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

10a. How many existing COBRA participants do you have? ___________

10b. Employees or COBRA/Cal-COBRA participants are required to complete a Disability Addendum (form C11248) if they are disabled or hospitalized.

Name of COBRA administrator: ____

COBRA member billing should be sent to the: ☐ Group ☐ COBRA administrator

Please provide COBRA administrator address:

Billing address		
City	State	ZIP code

Section 4a – Blue Shield of California health plan selection

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Trio HMO plans	
Select first plan	Select second plan
Select third plan	Select fourth plan
Access+ HMO® plans	
Select first plan	Select second plan
Select third plan	Select fourth plan
Trio HMO Savings plans*	
Select first plan	Select second plan
* Only available in the San Diego and Sacramento regions.	
Access+ HMO® SaveNet plans[1]	
Select first plan	Select second plan
1 Access+ HMO SaveNet products are only available alongside our Access+ HMO products in designated counties: Kern, Marin, Orange, Sacramento, San Francisco, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, Ventura, Yolo, and portions of Contra Costa, Los Angeles, Riverside, San Bernardino, and San Diego counties.	
Local Access+ HMO® plans[2]	
Select first plan	Select second plan
2 Local Access+ HMO products are only available in designated counties: Marin, Orange, San Francisco, San Luis Obispo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, and Yolo, and portions of Contra Costa, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, and Ventura counties.	
Added Advantage POS℠ plans	
Select first plan	Select second plan
Full PPO/EPO plans	
Select first plan	Select second plan
Select third plan	Select fourth plan
PPO Savings plans	
Select first plan	Select second plan
Select third plan	Select fourth plan
Tandem PPO/EPO plans	
Select first plan	Select second plan
Select third plan	Select fourth plan
Active Choice® Plus/Active Choice® Classic plans	
Select first plan	Select second plan

11 cont'd	**Blue Shield 65 Plus℠ plans**
	☐ Custom plan (attach custom Summary of Benefits)

12 **Required employer contribution for Blue Shield health plans**
Enter percentage of dues/premium paid by the group for employees and dependents. If the group contributes 100%, then all eligible employees must enroll.

Indicate medical plan employer contribution amount here:

For employees _________%	**For dependents** _________%
For retirees (if applicable) _________%	For retirees' dependents (if applicable) _________%

13 **Blue Shield account-based health plans (ABHP)**

Indicate if you are offering any of the following account options (check all that apply) and provide the name of the administrator of each program. Also indicate any amount to be funded by employer contribution.

Account type	Account administrator	Employer contribution amount INDIVIDUAL coverage	Employer contribution amount FAMILY coverage
☐ Health savings account (HSA)	☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims) • **Mandatory with medical enrollment:** ☐ Yes ☐ No ☐ Other administrator (non-integrated option)	$	$
☐ Health reimbursement arrangement (HRA)	☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims) • **Mandatory with medical enrollment:** ☐ Yes ☐ No ☐ Other administrator (non-integrated option)	$	$
☐ Health incentive account (HIA)	☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims) • **Mandatory with medical enrollment:** ☐ Yes ☐ No ☐ Other administrator (non-integrated option)	$	$
☐ Limited purpose flexible spending account (LPFSA – Dental and Vision) with HSA only	☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims) • **Mandatory with medical enrollment:** ☐ Yes ☐ No ☐ Other administrator (non-integrated option)	$	$
☐ Flexible spending account (FSA) ☐ Medical FSA ☐ Dependent care FSA	☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims) • **Mandatory with medical enrollment:** ☐ Yes ☐ No ☐ Ceridian (manual feed) ☐ Other administrator (non-integrated option)	$	$

Blue Shield of California optional benefits selection

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- Cannot be purchased without a medical plan.
- For Dual Choice packages, the same optional benefits must be purchased for all the plans selected.
- The rider product type must match the medical plan product type – only HMO to HMO, etc.

Infertility rider – select plan type:	**Select plan option:**
Select plan type	Select plan option
Chiropractic and acupuncture riders – select plan type:	**Hearing aid rider – select plan option:**
Select plan option	Select plan option

Blue Shield of California outpatient prescription drug plan options (available for HMO/POS)

Choose the Rx drug plan (Basic Rx) that applies:[1]	
Select option 1	Select option 2
Select option 3	Select option 4
Choose the Rx drug plan (Enhanced Rx or Premier Rx) that applies:[1]	
Select option 1	Select option 2
Select option 3	Select option 4
Choose the Rx drug plan (Rx Spectrum) that applies:[1]	
Select option 1	Select option 2
Select option 3	Select option 4

1 Tier 4 Drugs, including Specialty Drugs, 20% up to a $250 maximum.

14 cont'd

Blue Shield of California outpatient prescription drug plan options (available for PPO, EPO and Active Choice® Classic and Active Choice® Plus plans)

Choose the Rx drug plan (Enhanced Rx or Premier Rx) that applies:[1]

Select option 1	Select option 2
Select option 3	Select option 4

Choose the Rx drug plan (Rx Spectrum) that applies:[1]

Select option 1	Select option 2
Select option 3	Select option 4

1 Tier 4 Drugs, including Specialty Drugs, 30% up to $250 maximum.

Section 4b – Blue Shield Life health plan* and outpatient prescription drug plan* options

Check all boxes that apply:

Active Choice* plans

Select first plan [LIST OF PLANS]	Select second plan [LIST OF PLANS]

Choose one calendar-year pharmacy deductible option below:

☐ $0 per person ☐ $150 per person ☐ $250 per person

Choose an Rx drug plan option below:

Select first plan [LIST OF PLANS]	Select second plan [LIST OF PLANS]

1 Tier 4 Drugs, including Specialty Drugs, 30% up to a $250 maximum.

C17607-ML-MED

Blue Shield Life Health plan* optional riders

Hearing aid:

Would the group like to add a hearing aid rider? ☐ Yes ☐ No

Infertility

Choose one of the infertility riders:	Select option [LIST OF OPTIONS]

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Section SB1 – Blue Shield of California dental plan options:

15 **The group may select from one of the following plan options:**

☐ **Single Dental Plan Option**

☐ **Dual Choice Dental Plan Options**

- 1 DPPO + 1 DHMO
- 2 DHMOs
- 2 DPPOs

Dental HMO

Select first plan	Select second plan

Dental PPO

Select first plan	Select second plan

16 **Required employer contribution for dental plans**

Enter percentage of dues/premium paid by the group for employees and dependents. For dental coverage, the employer must contribute at least 50% of the employee's premium (except voluntary). If 100% is paid, all eligible employees must enroll.

Indicate dental plan employer contribution amount here:

For employees __________%
For retirees (if applicable) __________%

For dependents __________%
For retirees' dependents (if applicable) __________%

Section SB2 – Vision coverage*

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Select first plan	Select second plan

Vision Voluntary†

Select first plan	Select second plan

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

† A voluntary vision plan requires a minimum of 10 enrolling employees with Blue Shield Life medical coverage or 25% of eligible employees if without Blue Shield Life medical coverage.

C17607-ML-SB

18 **Required employer contribution for vision plans**
Enter percentage of premium paid by the group for employees and dependents. For vision coverage, the employer must contribute a minimum of 25% of the total employee's premium (except voluntary). If 100% is paid, all eligible employees must enroll.

Indicate vision plan employer contribution amount here:

For employees _________% For retirees (if applicable) _________%	**For dependents** _________% For retirees' dependents (if applicable) _________%

Section SB3 – Life/AD&D insurance*

19 **Eligibility** – All full-time employees

Employee life/AD&D insurance:

☐ **Flat amount** $ ___________________

☐ **Multiple of salary** _______ times salary, maximum $ ___________________

Benefit amounts established by salary are rounded to the next highest $1,000.

☐ **Graded:** 1. Class description ______________________ amount $ ______________________.
2. Class description ______________________ amount $ ______________________.
3. Class description ______________________ amount $ ______________________.
4. Class description ______________________ amount $ ______________________.

☐ **Dependent life insurance:** Select amount

The dependent coverage amount listed is per dependent, and coverage is only available for employees who also elect life insurance. Dependent benefit may not be more than 50% of the employee's benefit. Benefits for children ages 14 days to 6 months are 10% of dependent benefit.

20 **Required employer contribution for life insurance**
Enter percentage of premium paid by the group for employees and dependents. For life insurance coverage, the employer must contribute a minimum of 25% of the total employee's premium. If 100% is paid by the employer (non-contributory), all eligible employees must enroll.

Indicate life insurance contribution amount here:

For employees _________% For retirees (if applicable) _________%	**For dependents** _________% For retirees' dependents (if applicable) _________%

21 **Group Supplemental Life and Supplemental AD&D insurance*:** Coverage is subject to participation levels and Evidence of Insurability.

Employee Supplemental Life and Supplemental AD&D insurance (check all that apply):

☐ Supplemental Life insurance ☐ Supplemental AD&D insurance

Eligible class(es)___________ ☐ "All Eligible Employees" or ☐ Other________________________________

☐ Increments of $__________ ☐ Multiple(s) of salary:________________times salary

Maximum of $ ____________ Guaranteed issue of $ ____________

Spouse/domestic partner Supplemental Life and Supplemental AD&D insurance. Only available if employee also elects Supplemental Life insurance and cannot exceed 50% of the employee benefit amount. (Check all that apply):

☐ Supplemental Life insurance ☐ Supplemental AD&D insurance

Increments of $______________ to a maximum of $ ______________ Guaranteed issue of $ ____________

Child(ren) Supplemental Life and Supplemental AD&D insurance. Only available if employee also purchases Supplemental Life and Supplemental AD&D insurance and cannot exceed 50% of employee benefit amount.

Increments of $______________ to a maximum of $ ______________

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). C17607-ML-SB

Section 5 – Employer distribution of member *Evidence of Coverage/Certificate of Insurance* (EOC/COI)

22 You are responsible for the distribution of the EOC/COI booklets to your covered employees.

Electronic versions will be distributed via the Blue Shield employer website. Blue Shield will notify the individual responsible for EOC/COI distribution, identified in Section 1, #6 above, by email when the EOC/COI is ready for distribution. Employer is responsible for distributing these documents using one of the following methods: (1) posting on the company intranet for employee access, (2) emailing these documents directly to their employees, or (3) providing employees with instructions from Blue Shield about how to electronically retrieve the documents from the Blue Shield website.

Note: You can log in to **blueshieldca.com/policies** and download a *Summary of Benefits & Coverage* (SBC) for each plan you are considering. Once you purchase a plan(s), you will be asked to complete an attestation confirming you have downloaded the SBC(s) for those plans and will issue them to enrollees and prospective enrollees as required by law.

Payment (deposit check – this amount will be applied to the first month's premium)

23 The group herewith agrees to tender an initial deposit based on expected Blue Shield enrollment and, in consideration of approval of the application it will make and in event of such approval, promises to pay this company as appropriate any balance necessary to constitute the full initial payment for the group benefits herein identified on this form. It is understood that coverage will not commence until the application has been approved and the conditions of coverage are accepted by the employer.

Please note that depositing the group's check does not constitute approval of the group's application. Blue Shield of California will refund the full deposit to the group if the group application is declined.

Agreement

24 The group hereby applies for the group products selected on this application, as those benefit plans are outlined in the benefit summary(ies), with the understanding and agreement that:

1. Group benefits will not become effective, unless:
   a. Blue Shield receives and approves the application; and
   b. The group meets Blue Shield's underwriting requirements, including minimum participation and contribution requirements. (Participation and contribution requirements are required only upon renewal.)
2. The group agrees to pay the required monthly premium/dues to Blue Shield in a timely manner.
3. The group agrees to:
   a. Enroll all employees as they become eligible, if the Health Service Contract/Group Policy is issued on a non-contributory basis; or
   b. Give all eligible employees an opportunity to apply for such group benefits, if the Health Service Contract/Group Policy is issued on a contributory basis.
4. No waiver or requested change in coverage will become effective unless agreed to and signed by an officer of Blue Shield.
5. For life insurance/AD&D products only: enrolling employees must be actively at work or meet the active employment provisions for coverage before coverage may become effective. Coverage for any person not meeting these provisions on the effective date of the Group Policy, or any increase in coverage for any person not meeting these provisions on the effective date of such increase in coverage, will be deferred until the person returns to work or active employment.
6. The group consents to and authorizes Blue Shield to send all business correspondence through electronic communications. Blue Shield will notify the group contact, identified in Section 1, #6 above, by email. Other forms of contact will only be made upon direct request. Employers requesting mail correspondence may incur an additional cost.

It is understood that the group agrees to receiving electronic communications from Blue Shield.

Authorization and signature

25 The following authorization section must be signed by the primary group representative/contact.

This is an application for coverage. The group understands that no contract for coverage will exist until Blue Shield has completed its review and communicated to the applicant or the applicant's producer that the application has been accepted and a group health service contract has been issued. The group representative certifies, to the best of his or her knowledge and belief, all of the responses provided in this application are true, correct, and complete. The group understands that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application, Blue Shield of California may pursue one of the following remedies within the first 24 months of coverage: group coverage may be cancelled, or the applicable premium/dues may be adjusted, or following notice, the Health Service Contract/Group Policy may be rescinded.

I certify to the best of my knowledge and belief that all responses given above are true and correct and complete.

Authorized group representative signature	Name and title (please print)	Date

Producer information (To be completed by producer or general agent. All information is required.)

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Field		
Primary producer company name		
Primary producer contact name	Primary producer contact phone number	
Primary producer office address		
City	State	ZIP code
Primary producer contact email		
Primary producer Tax ID number		
Primary producer contact Department of Insurance license number		
Secondary producer company name		
Secondary producer contact name	Secondary producer contact phone number	
Secondary producer office address		
City	State	ZIP code
Secondary producer contact email		
Secondary producer Tax ID number		
Secondary producer contact Department of Insurance license number		
Today's date (required)	Primary producer signature (required)	Print producer name
Today's date (required)	Secondary producer signature (when applicable)	Print producer name

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Field		
General agency Tax ID number		
General agency name		
Today's date (required)	General agent authorized signature (required)	Print general agent contact name

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Blue Shield of California is an independent member of the Blue Shield Association A20275 (12/19)

Notice of the Availability of Language Assistance Services

Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíínίłta'go bííníghah? Doo bííníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hólǫ́. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníít nínízingo bííghah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíílnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 7198-346 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 7198-346 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

Notice of the Availability of Language Assistance Services

Blue Shield of California Life & Health Insurance Company

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

無料の言語サービス　日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、ＩＤカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند.برای دریافت کمک،با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید.برای دریافت کمک بیشتر، به CA Dept. of Insurance(اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید.Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ' ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากล่าม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

Doo bááh ílínígó saad bee yát'i' bee aná'áwo'. Díí shá ata'halne'dooígí hólǫ́ǫdoo nínízingo éí bíighah. Naaltsoos naanináhájeehígí shich'į' yíidooltah éí doodagó ła' shich'į' ádoolnííł nínízingo bíighah. Shíká a'doowoł nínízingo nihich'į' béésh bee hodíilnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866)346-7198jį' hodíilnih. Hózhǫ́ shíká anáá'doowoł nínízingo éí díí béeso ách'ąąh naa'nil bił haz'ą́ąjį' 1-800-927-4357jį' hodíílnih. Navajo

ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີໃນບັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງລັດຄາລີຟໍເນຍໄດ້ທີ່ເບີ1-800-927-4357. Laotian